Part 4: Notes

1. VERMONT DEPARTMENT OF DEVELOPMENTAL AND MENTAL HEALTH SERVICES

The Vermont Department of Developmental and Mental Health Services (DDMHS) is responsible for a variety of publicly funded outpatient, inpatient, residential and support services provided to children and adults who have an emotional disturbance, mental illness, and/or a developmental disability. These services are provided to individuals throughout the state under the auspices of the DDMHS Mental Health Division and Developmental Services Division, for the most part through contracts with nonprofit community providers. DDMHS contracts with one designated agency (DA) in each geographic region of the state to be responsible for ensuring needed services are available through local planning, support coordination and outcomes monitoring within their region. A specialized service agency (SSA) is a separate entity also contracted by DDMHS that provides community services to a specific population. Contracted providers (CP) are used only within the developmental service system and are contracted through DAs and SSAs. This report describes clients served and services provided during FY2002 by the Vermont State Hospital, eleven designated agencies, five specialized service agencies and two certified providers.

The Mental Health Division is responsible for the Vermont State Hospital and mental health programs at Vermont's designated agencies, including Children's Services programs, Adult Mental Health Outpatient programs, Community Rehabilitation and Treatment programs, and Emergency Services programs. Many community mental health providers also provide substance abuse services under contract with the State's Division of Alcohol and Drug Abuse Programs in the Health Department. The Developmental Services Division is responsible for Developmental Services programs at Vermont's designated agencies, specialized service agencies and certified providers. On intake, most clients are assigned to one of these programs within the agency (primary program assignment), although the services they receive may be provided by more than one program in that agency (program of service). It should be noted that guardianship services provided by the Developmental Services Division to adults with developmental disabilities are not included in this report.

The Vermont State Hospital (VSH) is a state-operated psychiatric hospital located in Waterbury, Vermont. The hospital serves patients on both a short-term and a long-term basis. Short-term patients include individuals who are experiencing an acute psychotic episode and criminal defendants referred to the hospital for psychiatric evaluation of sanity and/or competency to stand trial. The law requires that patients must be deemed to be in need of treatment not available in a less restrictive setting. Longer-term patients include patients with a chronic mental illness who continue to be too actively psychotic to be integrated into the community, and patients whose mental disorders and physical handicaps require a higher or more specialized level of care than is available in the community. Inpatient behavioral health care is also provided by four regional hospitals in Vermont and the Brattleboro Retreat; data on clients served by these facilities are not included in this report.

Children's Services programs provide services to children and families who are undergoing emotional or psychological distress or are having problems adjusting to changing life situations. These programs primarily provide outpatient services (clinical, service planning, community supports, crisis, vocational and respite services), although several agencies also provide residential services for children and adolescents who have a severe emotional disturbance.

Adult Mental Health Outpatient programs serve individuals over 18 years of age who do not have prolonged serious disabilities but who are experiencing emotional, behavioral, or adjustment problems severe enough to warrant professional attention. Services offered include clinical, service planning and community support services and some crisis services.

Community Rehabilitation and Treatment (CRT) programs serve adults with severe and persistent mental illness. In addition to regular clinical services, CRT programs provide day treatment services, service planning, community supports, supported employment and a variety of housing services to clients who have a major mental illness.

Substance Abuse programs provide services to people with alcohol and/or drug abuse problems and their families in a community setting. These services include individual and group treatment, diagnosis and evaluation, and intensive day services.

Emergency Services programs serve individuals who are experiencing an acute mental health crisis. Emergency services include diagnostic and psychotherapeutic services such as evaluation of the client and the circumstances leading to the crisis, crisis counseling, screening for hospitalization, referral and follow-up. These services are provided on a 24-hour a day, 7-day-per-week basis with both telephone and face-to-face services available as needed.

The Developmental Services Division provides services to adults and children with a developmental disability and their families. Developmental Services programs provide a comprehensive range of services designed to support individuals and families at all levels of need. These services include service planning and coordination, community and employment supports, clinical and crisis services, family supports and home supports. Home supports include developmental homes (shared living), supervised living, staffed living, group homes and two Intermediate care facilities (ICF/MR). Services for individuals with developmental disabilities are provided through 16 non-profit agencies located throughout the state. Ten are designated agencies, five are smaller specialized service agencies, and two are certified providers. Starting in FY2001, this report includes details of the clients and the services they receive from Specialized Community Care and Vermont Supported Living. Data for clients served by Families First are not currently included in this report.

2. Community Provider Agencies

Community services are provided to individuals throughout the state through contracts with nonprofit community provider agencies. The community provider agencies are designated by DDMHS at differing levels: designated agencies (DAs), specialized service agencies (SSAs) and contracted providers (CPs). The agencies and the areas they serve are described below.

Designated Agencies

DDMHS funds community mental health and developmental services provided by designated agencies (DAs). Each DA serves a specific service or catchment area. Together these mental health and developmental service catchment areas cover the entire state. Population figures for these catchment areas are based on Census 2000 data obtained from the Center for Rural Studies at the Vermont Department of Health.

The Counseling Service of Addison County (CSAC) serves all of Addison County except the towns of Granville and Hancock.

Northwestern Counseling and Support Services (NCSS) serves Franklin County and Grand Isle County.

The Howard Center for Human Services (HCHS) serves Chittenden County.

Lamoille County Mental Health Services (LCMHS) serves Lamoille County. For Children's Services, Lamoille also serves the towns of Craftsbury, Greensboro, Hardwick, and Standard from the Northeast Kingdom, and Woodbury from Washington County.

Health Care and Rehabilitation Services of Southeastern Vermont (HCRSSVT) serves all of Windham County and Windsor County except the towns of Bethel, Rochester, Royalton, Sharon and Stockbridge.

Northeast Kingdom Human Services (NKHS) serves Caledonia, Essex and Orleans Counties except the towns of Craftsbury, Greensboro, Hardwick, and Standard for Children's Services.

The Clara Martin Center (CMC) provides mental health services only. CMC provides mental health services to people living in Orange County as well as the towns of Granville and Hancock in Addison County and the towns of Bethel, Rochester, Royalton, Sharon and Stockbridge in Windsor County.

Rutland Mental Health Services (RMHS) serves Rutland County.

United Counseling Services (UCS) serves Bennington County.

Washington County Mental Health Services (WCMHS) serves Washington County as well as the towns of Orange, Williamstown, and Washington from Orange County, but with the exception of the town of Woodbury for Children's Services.

Upper Valley Services (UVS) provides developmental services only. UVS provides comprehensive developmental services to people living in Orange County as well as the towns of Granville and Hancock in Addison County and the towns of Bethel, Rochester, Royalton, Sharon and Stockbridge in Windsor County. This agency also provides comprehensive developmental services to some people living in Washington County.

Specialized Service Agencies

DDMHS contracts with five SSAs. Each SSA provides community services to a specific population.

The Northeastern Family Institute (NFI) in Williston provides intensive residential treatment for children and adolescents who are emotionally disturbed from all parts of the State of Vermont.

Champlain Vocational Services (CVS) provides community supports, employment supports and some limited housing supports to people with developmental disabilities living in Chittenden County.

Lincoln Street, Inc. (LSI) provides comprehensive developmental services to people living primarily in southeast Vermont.

Sterling Area Services (SAS) provides comprehensive developmental services to people living primarily in Lamoille County.

Specialized Community Care (SCC) provides comprehensive developmental services to people living primarily in Addison and Rutland counties.

Contracted Provider Agencies

The Developmental Service System has two contracted providers (CPs).

Vermont Supported Living (VSL) provides comprehensive family support services primarily to children with developmental disabilities, living in Orange county and southeast Vermont.

Families First (FF) provides family support services to people with developmental disabilities living primarily in Windham County. Data on clients served by FF are not included in this report.

3. Clients Served

This report is based on a complete enumeration of clients served by Children's Services programs, Adult Mental Health Programs, Community Rehabilitation and Treatment programs, Emergency Service programs, Substance Abuse programs, Developmental Services programs and by the Vermont State Hospital. Although clients may receive services from more than one of these community-based programs, each client has a primary program assignment within the agency providing the services. Clients involved in other programs such as Retired Senior Volunteers programs (RSVP), Head Start programs, and Counter Measures Regarding Alcohol Safety on the Highway (CRASH) programs are included only if they were also served by one of the programs listed above. Clients served by Emergency Service programs are included in this report only if they become registered clients of the agency. In some cases, clients who receive only emergency services do not become registered clients of the agency. It should be noted that the clients and services reported for NFI include only those who receive DDMHS funded services.

Tables that describe clients categorize them according to their primary program assignment rather than the program(s) by which they were served. Because of this, the numbers of clients served within each community service provider agency and VSH represent an unduplicated count of individual clients. Clients served by more than one program at a provider agency are counted only once. Individuals who were served by more than one provider agency, however, are counted more than once, as are individuals served by a provider agency and VSH. Table entries with the symbol "-" indicate either "no data reported" or "not applicable". Due to rounding, table entries with 0% indicate percentages that are less than 0.5%.

Clients who had not been assigned to a specific program as of the end of the fiscal year are reported as "unassigned" in the tables based on primary program assignment. At most community provider agencies, these are primarily clients who have only been seen on an emergency basis, and clients who have only recently entered treatment. (Statewide, 41% of the clients who were not assigned to a specific program at the end of FY2002 had received only emergency services during that year.) DAs that report serving more emergency service clients tend to report more unassigned clients.

Tables that describe services provided by programs at community provider agencies categorize clients according to the program by which services were provided. Because of this, clients who received services from more than one program of service are counted more than once in tables that describe services provided. Thus, the client totals in the tables that describe services do not equal the client totals in the tables that describe demographics. Table entries with the symbol "-" indicate either "no data reported" or "not applicable". Due to rounding, table entries with 0% indicate percentages that are less than 0.5%.

It should be kept in mind that many DAs do not register or record mental health services to every individual who might be seen in the course of client treatment. Collaterals, such as parents, children, or spouses of registered clients, for instance, frequently receive services coincident to services to the primary client. Family therapy is especially likely to involve individuals who do not become registered clients so that the number of clients reported would be substantially fewer than the actual total number of individuals seen.

The rate of clients served per 1,000 population in Table 1-2 is presented as a comparable standardized measure of the proportion of the residents of specified geographical regions who are served by specified programs. This utilization rate is computed according to the formula:

$$R = \frac{1{,}000C}{P}$$

where R is the rate of clients served per 1,000 population, C is the number of clients served, and P is the age-specific population of the geographic area in question. Children's Services utilization rates are based on the catchment area population of residents under 18 years of age. CRT, Adult Mental Health Outpatient, Substance Abuse and VSH service utilization rates are based on adult population counts. Total population counts are used to calculate utilization rates for Developmental Services and unassigned clients. Note that in prior versions of this report all program utilization rates were computed on the basis of total population figures. Counts for the catchment area populations were based on National Census figures obtained from the Vermont Center for Rural Studies at the University of Vermont:

Provider / Catchment Area		Child	Adult	Total
CSAC	Addison	8,779	26,510	35,289
NCWSS	Franklin/Grand Isle	14,471	37,847	52,318
HCHS	Chittenden	34,513	112,058	146,571
LCMHS	Lamoille	5,645	17,588	23,233
HCRSSVT	Southeast	21,986	71,821	93,807
NKHS	Northeast	15,770	46,668	62,438
CMC/UVS	Orange	9,226	27,512	36,738
RMHS	Rutland	14,739	48,661	63,400
UCS	Bennington	8,758	28,236	36,994
WCMHS	Washington	13,636	44,403	58,039

4. Age

The age of clients was calculated from their date of birth and is current as of December 31, 2001, the midpoint of the period covered by this report.

5. Income

Income is based on clients' or their families' report of gross annual household income. The income reported should include all sources of income including Supplemental Security Income (S.S.I.) benefits, welfare payments, unemployment compensation, alimony and child support payments, in addition to income earned from employment or investment. All income from all members of a residential/economic unit should be included. If a client lives with

unrelated others with whom he or she does not pool financial resources, income of the other resident(s) should not be counted toward the client's income.

Low reporting rates at some clinics are due in part to a local policy of not collecting income information from Medicaid clients. Statewide, income data were provided for 45% of all clients served during FY2002. Of those missing income data, about half were Medicaid clients.

6. Responsibility for Fee

Responsibility for fee is reported for five categories: Medicaid, Medicare, other insurance, state agency contract, and uninsured. Providers can report up to three payers for each client. Therefore, the categories are not mutually exclusive and clients may be counted in more than one category. "Medicaid" includes all clients who are covered by Medicaid, including people on the Medicaid Waiver. "Other Insurance" includes all clients with other third-party insurance excluding Medicaid and Medicare. This category includes private insurance, service contracts, Veterans Administration, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and worker's compensation. "State Agency Contracts" includes clients whose services are partly funded by DDMHS, ADAP, SRS and Vocational Rehabilitation contracts. Finally, the "Uninsured/unknown" category is the residual category for clients who are not reported in any of the other categories noted above.

Medical insurance does not necessarily cover mental health services and, even when these services are covered, the reimbursement may be substantially less than the cost of the services. Because of this, insured clients should be considered partly self-paying clients as well.

Information on responsibility for fee presented here is current as of the end of the report period (06/30/02). Since insurance coverage is subject to change, the insurance coverage reported here may not have been in effect for the entire year of the report. Due to an error in coding, a number of Children's Services clients receiving Medicaid and Medicaid waiver services at NKHS were recorded as Medicare recipients. This number has been excluded from the counts recorded for Medicare for NKHS.

7. Diagnosis

Diagnostic categories included in this report are based on the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM IV). Clients may receive more than one diagnosis. These clients will be reported under more than one diagnostic group. For this reason, the total number of diagnoses will exceed the total number of clients served. Specific diagnoses have been grouped into diagnostic categories according to the following specifications:

Organic Brain Syndromes:
- Senile and Presenile Dementias (290.1x, 290.20, 290.21, 290.30, 290.4x, 209.00);
- Some Organic Brain Syndromes (293.00, 293.81, 293.82, 293.83, 294.00, 294.10, 294.00, 294.10, 294.80, 310.10);
- Psychoactive Substance-Induced Organic Mental Disorders (291.00, 291.10, 291.2x, 291.30, 291.40, 291.80, 292.00, 292.11, 292.12, 292.81, 292.82, 292.83, 292.84, 292.89, 292.90).

Schizophrenic and Other Psychotic Disorders:
- Schizophrenic Disorders (295, 1x, 295.2x, 295.3x, 295.9x, 295.6x);
- Paranoid Disorders (297.10, 297.30, 297.90, 298.30);
- Autism (299.0x, 299.8x, 299.9x);
- Psychotic Disorders not Classified Elsewhere (295.40, 295.70, 298.80, 298.90).

Affective Disorders:
- Major Affective Disorders (296.2x, 296.3x, 296.4x, 296.5x, 296.6x);
- Other Specific Affective Disorders (300.40, 301.13, 311.00)
- Atypical Affective Disorders (296.70, 296.82).

Anxiety Disorders:
- Phobic Disorders (300.21, 300.22, 300.23, 300.29);
- Anxiety Neuroses (300.01, 300.02, 300.30);
- Post Traumatic Stress Disorder (300.00, 308.30, 309.81, 309.89).

Personality Disorders:

Personality Disorders (301.00, 301.20, 301.22, 301.40, 301.50, 301.60, 301.70, 301.81, 301.82, 301.83, 301.84, 301.90);
Factitious Disorders (300.16, 300.19, 301.51).

Adjustment Disorders:

Adjustment Disorders (309.00, 309.23, 309.24, 309.28, 309.30, 309.40, 309.82, 309.83, 309.90).

Social Problems:

Conditions Not Attributable to a Mental Disorder that are a Focus of Attention or Treatment (15.81, 61.10, 61.20, 61.80, 62.20, 62.30, 62.82, 62.88, 62.89, 65.20, 71.01, 71.02).

Substance Abuse:

Substance Use Disorders (303.9x, 304.0x, 304.1x, 304.3x, 304.4x, 304.6x, 304.7x, 304.8x, 304.9x, 305.0x-305.7x, 305.9x);

Childhood Non-Psychotic Disorders:

Attention Deficit Disorder (314.00, 314.01, 314.80);
Conduct Disorder (312.00, 312.20, 312.90, 313.81);
Anxiety Disorders of Childhood or Adolescence (309.21, 313.00, 313.21).

Other Psychological Disorders:

Gender Identity Disorders (302.5x, 302.60, 302.85);
Paraphilias (302.10, 302.20, 302.30, 302.40, 302.81-302.84, 302.90);
Psychosexual Dysfunctions (302.70-302.76, 306.51);
Other Psychosexual Disorders (302.00, 302.89);
Psychological Factors Affecting Physical Conditions (316.00);
Disorders of Impulse Control (312.31-312.35, 312.39).

Mental Retardation/Developmental Disorders:

Mental Retardation (317.0x, 318.0x-318.2x, 319.0x);
Specific Developmental Disorders (315.00, 315.10, 315.31, 315.39, 315.50, 315.90).

8. Problems

Part of the intake process for each client is a problem checklist. Beginning in FY2000, four problem areas not previously reported (Mood, Criminal, Victim and Runaway) were added to the problem list table. The problem areas are not mutually exclusive, as an individual may have more than one type of problem. Since this assessment is conducted only at intake, the problems may not be current for long-term clients. Problems apparent at intake may have been resolved and/or new problems may have arisen. This information is not collected for clients treated at the Vermont State Hospital or for Developmental Services.

9. Length of Stay

Information on clients' length of stay is based on admission dates reported by community provider agencies and VSH. These dates represent the most recent admission for the clients, not the date of their first admission. For this reason, these figures may substantially understate the total length of time clients have been in treatment.

Community programs vary in their standard operating procedures with regard to discharging and readmitting clients. Some programs routinely discharge clients after specified periods of inactivity. Other programs rarely discharge long-term clients with severe and persistent disorders.

10. Clinical Interventions

During FY 2001, new codes for reporting services were adopted. A broad clinical interventions classification was introduced which includes assessment, therapeutic, medication or medical services provided by clinical or medical staff, including a qualified clinician, therapist, psychiatrist or nurse.

Starting with the FY2001 edition, the Statistical Report reports on the broad clinical intervention classification and, for those who require a more detailed breakdown, also reports on the separate categories of clinical services. The separate categories (accompanied by the terms used to describe them in previous editions of the Statistical Report) are described below.

Individual, Family and Group Therapy (Formerly Individual and Group Services)

Individual, Family and Group Therapy refers to all psychotherapeutic services. Individual Therapy is a method of treatment that uses the interaction between a therapist and the individual to facilitate emotional or psychological change and to alleviate distress. Family Therapy is a method of treatment that uses the interaction between a therapist, the individual, and family members to facilitate emotional or psychological change and to alleviate distress. Group Therapy is a method of treatment that uses the interaction between a therapist, the individual, and peers to facilitate emotional or psychological change and to alleviate distress.

Psychotherapeutic services described in this report refer to services received by clients. A group therapy session in which one clinician meets with five clients, for instance, is counted as five services. Individual therapy sessions involving couples or families may involve multiple services as well. Individual and family therapy sessions tend to last about one hour. Group therapy sessions average about 1 1/2 hours statewide. Individual, family and group therapy services are reported for nonresidential programs only.

Medication and Medical Support and Consultation Services (Formerly Chemotherapy Services)

Medication and Medical Support and Consultation Services include evaluating the need for, prescribing and monitoring medication, and providing medical observation, support and consultation for an individual's health care. As such it includes evaluation of the need for psychoactive medication, the prescription by a qualified clinician, therapist, psychiatrist or nurse of psychoactive drugs intended to favorably influence or prevent symptoms of mental illness and the monitoring and assessment of patient reaction to prescribed drugs. Medication and Medical Support and Consultation Services average almost one hour in duration, and are reported for nonresidential programs only.

Clinical Assessment (Formerly Diagnosis and Evaluation Services)

Clinical Assessment refers to psychiatric, psychological, psychosocial and/or developmental assessment sessions and the preparation of individualized plans, including the administration and interpretation of psychometric tests and the preparation of reports. Clinical Assessment services average about 1 hour and 20 minutes in duration and are reported for outpatient programs only when they are recorded as a separate service. In some developmental services programs, clinical assessment is considered part of the general service package and is not recorded separately.

Assessment Bed

Assessment Bed, a new service category, is needed to provide an intensive time-limited (maximum 60 days) stable setting to formulate a diagnosis; to evaluate an individual's and family strengths and needs; and to begin service planning and coordination, therapy, community supports; and medication services as necessary. This is for children's services only and is an exception to most assessments that are done in a child's home, school or community. A breakdown of these services by provider is not given in Part 2A as there is only one regional children's services program that provides assessment bed services. During FY2002, NFI provided assessment bed services to 23 young clients.

11. Day Services

The Day Services reported in this book include community-based Day Services and Partial Hospitalization.

Day Services are group recovery activities in a milieu that promote wellness, empowerment, a sense of community, personal responsibility, self-esteem and hope. These activities are consumer-centered. This service provides socialization, daily skills development, crisis support and promotes self-advocacy. The primary providers of Day Services are Community Rehabilitation and Treatment programs and Substance Abuse programs. Note that Developmental Services programs do not provide day services. Daytime activities and supports for Developmental Services clients are provided either through Community Supports or Employment Services.

Partial Hospitalization is an intensive (4-16 hours/day), time-limited (maximum 21 days) service provided as an alternative to inpatient care to prevent or shorten psychiatric hospitalization and promote recovery. Partial Hospitalization services are provided to individuals who would otherwise meet inpatient criteria, and medical personnel (nurse, physician) are accessible to provide services during hours of operation. Treatment modalities include diagnosis and evaluation; service planning and coordination; community supports; individual, group and family therapy; medication services and psycho-educational skill development for managing symptoms. Developmental Services programs do not provide this service. During FY 2002, RMHS provided Partial Hospitalization services to 74 clients in the Adult Mental Outpatient program and 17 clients in the CRT program.

12. Service Planning and Coordination

Service Planning and Coordination is one of the new service reporting categories adopted during FY 2001. These services were previously reported under the broader Case Management category, which is no longer used. Service Planning and Coordination assists individuals and their families in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of needed services and supports for a specific individual. Services and supports that are planned and coordinated may be formal (provided by the human services system) or informal (available through the strengths and resources of the family or community). Services and supports include discharge planning advocacy and monitoring the well being of individuals (and their families), and supporting them to make and assess their own decisions.

13. Community Supports

Community Supports is one of the new service reporting categories adopted during FY 2001. These services were previously reported under the broader Case Management category, which is no longer used.

Community Supports include specific, individualized and goal-oriented supports, which assist individuals (and families) in developing the skills and social supports necessary to promote positive growth. These supports may include assistance in daily living, supportive counseling, support to participate in community activities, collateral contacts, and building and sustaining healthy personal, family and community relationships. All of these activities may also be provided in a group setting. Community supports may further include family education, consultation and training services that provide family members, significant others, home providers and foster families with the knowledge, skills, and understanding necessary to promote positive change.

14. Employment Services (Formerly Vocational Services)

Employment Services assist transition age youth and adults in establishing and achieving career and work goals. These services consist of four component parts. Employment assessment involves evaluation of the individual's work skills, identification of the individual's preferences and interests, and the development of personal work goals. Employer and job development assists an individual to access employment and establish employer development and support. Activities for employer development include identification, creation or enhancement of job opportunities, education, consulting, and assisting co-workers and managers in supporting and interacting with individuals. Job training assists an individual to begin work, learn the job, and gain social inclusion at work. Ongoing support to maintain employment involves activities needed to sustain paid work by the individual. These supports and services may be given both on and off the job site, and may involve long-term and/or intermittent follow-up.

Part 1 reports provision of these services by program of service. A further breakdown by community provider for Community Rehabilitation and Treatment Programs and Developmental Programs, the primary providers of these services, is given in Part 2C. A breakdown of vocational services by provider is not given in Part 2A since there are only two regional children's services programs that provide employment services for transition age youth. During FY2002, NCSS provided employment services to 62 youth and WCMHS provided employment services to 32 youth. Services provided to participants in the seven J.O.B.S. programs for youth in state will be separately reported in future reports.

15. Crisis Services

Separate reports on Crisis Services were added for the FY2001 edition of the Statistical Book. In previous reports, certain services provided by the Emergency Services Program were included in the tables reporting clinical

services. Crisis Services are time-limited, intensive, supports provided for individuals, and families, who are currently experiencing, or may be expected to experience, a psychological, behavioral, or emotional crisis. Services may also be provided to the individual's or family's immediate support system. These services are available 24 hours a day, 7 days a week. During FY2002, some Designated Agencies reported Crisis Services provided by Emergency Services programs as if they had been provided by CRT programs in order to consolidate services reimbursed by CRT case rates.

Crisis Services consist of two component parts, Emergency/Crisis Assessment, Support and Referral, and Emergency Beds, the activities of which are described below.

Emergency/Crisis Assessment, Support and Referral

Emergency/Crisis Assessment, Support and Referral is a nonresidential service. Emergency/Crisis Assessment, Support and Referral includes initial information gathering, triage, training and early intervention, supportive counseling, consultation, referral and crisis planning. In addition, supports include: outreach and stabilization, clinical diagnosis and evaluation, treatment and direct support, and integration/discharge planning back the person's home or alternative setting. Assessment may also include screening for inpatient psychiatric admission. Emergency/Crisis Assessment, Support and Referral services provided by NFI are excluded from this report, since a full breakdown of these services was not available at the time of publication.

Emergency/Crisis Beds

Emergency Beds offer emergency, short-term, 24-hour residential supports in a setting other than the person's home. Part 1 reports provision of these services by program of service. A further breakdown by community provider for Community Rehabilitation and Treatment Programs, the primary provider of these services, is given in Part 2C.

16. Housing and Home Supports (Formerly Residential Services)

Housing and Home Supports provide services, supports and supervision to individuals in and around their residences up to 24 hours a day.

Residential services (by the day) are provided in a variety of settings. Staffed Living services are residential living arrangements for one or two people, staffed full-time by providers and Group Treatment/Living services are group living arrangements for three or more people. Licensed Home Providers/Foster Families are individualized shared-living arrangements for children, offered within a home provider's/foster family's home that is licensed. Home providers/foster families are contracted workers and are not considered staff in their role as contracted provider. Unlicensed Home Providers/Foster Families are individualized shared-living arrangements for children and adults, offered within a home provider/foster family's home. Home providers/foster families are contracted workers and are not considered staff in their role as contracted provider. ICF/MR (Intermediate Care Facility for people with Mental Retardation) is a highly structured residential setting for up to six people that provides needed intensive medical and therapeutic services. All of the above services consist of residential days. Where residential services are reported to DDMHS in terms of hours in residence during periods of more than one day, the total residential days is derived by dividing the total residential hours by 24. Residential services in these settings frequently include planning and coordination together with other therapeutic, educational and supportive services as part of the overall residential service package.

Supervised/Assisted Living services (by the hour) are regularly scheduled or intermittent supports provided to an individual who lives in his or her home or that of a family member. These services are not provided by Children's Services Programs. Supervised/Assisted Living services are reported in Part 2F for Developmental Services, the primary provider of these services.

Residential facilities in the community that house community mental health and/or developmentally disabled clients but are not funded by the Department of Developmental and Mental Health Services are not included in this report. These facilities include community care homes, nursing homes, boarding houses, some intermediate care facilities for individuals with developmental disabilities, and a number of other residential settings. Residential substance abuse treatments provided by designated agencies are also excluded from this report.

Institutional services are days in residence at the Vermont State Hospital. The day on which patients were admitted to these institutions is included, while the day patients were discharged is excluded. Residential services provided at the Brattleboro Retreat are not included in this report.

17. Respite Services

Reports on Respite Services were added for the FY2001 edition of the Statistical Report. Respite services assist family members, significant others (e.g., roommates, friends, or partners), home providers, and foster families to help support specific individuals with disabilities. Respite (by the hour or by the day/overnight) services are provided on a short-term basis because of the absence, or need of relief, of those persons normally providing care to individuals who cannot be left unsupervised. Respite services are provided by Children's Services programs and Developmental Services programs only.

18. Condition on Termination

Clinical staff are asked to rate the condition of each client whose case is closed as "improved," "unchanged," or "worse." These ratings represent the professional opinion of the clinicians. Condition on termination is not reported by the Vermont State Hospital or Developmental Services.

Discharge rates reported for designated agency clients may underestimate the actual rates. This occurs because it was not possible to identify clients who were discharged during a quarter in which they received services and their condition on termination had not yet been rated.

Clients who died while they were on the rolls of the community program or institutions are counted as discharged clients and are included in the discharge rate.

19. Admissions and Discharges

Admissions to and discharges from the Vermont State Hospital include both first admissions and readmissions. Individuals with more than one admission or discharge during the year have been counted more than once in these totals.

For purposes of calculating total patient days and overall daily census, the day each patient is admitted to the hospital is counted as a full day in residence, while the day each patient is discharged is not counted as a day in residence.

20. Legal Status

Patients are admitted to the Vermont State Hospital in one of several legal statuses. These have been grouped into four categories for purposes of this report: voluntary, emergency, forensic and other. Emergency, forensic and other admissions are all involuntary admissions to the Vermont State Hospital.

Voluntary admissions include conditional voluntary admissions and regular voluntary admissions. In order to qualify as a conditional voluntary admission, the patient must have enough insight and capacity to make a responsible application. He or she must be mentally ill and in need of hospitalization. He or she must want to be admitted to the hospital as a voluntary patient; no third party may sign the patient in. Conditional voluntary patients must sign a consent form for admission which states that they understand their treatment will involve inpatient status, that they desire to be admitted to the hospital, and that they consent to admission voluntarily, without any coercion or duress. There is no special time limit on this type of admission. When the treatment team feels the patient is well enough to leave the hospital, he or she may be placed on a pre-placement visit, conditionally released, or discharged.

Regular voluntary admissions are similar to conditional voluntary admissions except that the patient must be discharged immediately when he or she gives notice.

Of the 14 voluntary admissions to the Vermont State Hospital during FY2002, all were conditional voluntary admissions; none were regular voluntary admissions.

Emergency admission includes admissions for emergency examination and admissions under a warrant for immediate examination. Admissions for emergency examination occur upon written application by an interested party accompanied by a certificate signed by a licensed physician who is not the applicant. The application sets forth the facts and circumstances which constitute the need for an emergency examination and which show that the person is in need of treatment. After being examined by a VSH psychiatrist and found to be in need of hospitalization, the application for involuntary treatment is filed with the Waterbury Circuit Court. A hearing date is then set. (Patients are sometimes administratively discharged or conditionally released prior to the hearing date.)

Admissions under a warrant for immediate examination occur in emergency circumstances in which a certification by a physician is not available without serious and unreasonable delay and when personal observation of the conduct of a person constitutes reasonable grounds to believe that the person is in need of treatment and that he or she presents an immediate risk of serious injury to self or others if not restrained. A law enforcement officer or mental health professional may make an application, not accompanied by a physician's certificate, to any district or superior judge for a warrant for an immediate examination. If the judge is satisfied that a physician's certificate is not available without serious and unreasonable delay and that probable cause exists to believe that the person is in need of an immediate examination, the judge may order the person to submit to an immediate examination at the Vermont State Hospital. Upon admission, he or she shall be immediately examined by a licensed physician. If the physician certifies that the person is in need of treatment, the person shall be held for an emergency examination (discussed above). If not certified, the person must be discharged immediately.

Of the 115 emergency admissions to the Vermont State Hospital during FY2002, 110 involved emergency examinations and 5 were under a warrant for immediate examination.

Forensic admissions include admissions for court-ordered observation and commitments following competency and hospitalization hearings. Admissions for observation occur when a district court sends a criminal defendant to the Vermont State Hospital for psychiatric evaluation. An outside forensic psychiatrist sees the patient to determine if he or she was insane at the time of the alleged offense, had the mental state required for the offense charged, or is competent to stand trial for the alleged offense. These orders vary from 15 to 60 days. These patients cannot leave the hospital or be released from the hospital without an order from the court. Once the examination has been completed and the evaluation is received by the court, a hearing date is set for final disposition.

A commitment following a competency and hospitalization hearing is a civil commitment following an observation order and a hearing on the question of competency to stand trial and sanity at the time of the offense. In most cases it means that a person has been found not competent to stand trail and in need of hospitalization. All relaxation of restrictions must be approved by the head of the hospital. Some patients have to be returned to court before being released to the community, and in these cases all requests for relaxation of restrictions must be approved by the head of the hospital and the Commissioner. Prior to discharge, clear-cut aftercare plans must be approved by the head of the hospital, and the state's attorney requires a 10-day written notice prior to any release.

Of the 97 forensic admissions to the Vermont State Hospital during FY2002, 89 were for observation and 8 were for commitment following competency and hospitalization hearings.

Other types of legal status include revocation of conditional release, revocation of orders of non-hospitalization, involuntary court commitment for 90 days, and transfers under interstate compact. A revocation of conditional release occurs when the head of the hospital revokes a conditional discharge before that discharge becomes absolute because the patient failed to comply with the conditions of the discharge. A revocation of orders of non-hospitalization occurs when a judge revokes an order of non-hospitalization because the patient failed to comply with the conditions of the order. An involuntary court commitment for 90 days applies to a patient who has been committed by the court after having been found mentally ill and in need of treatment. This is a civil commitment for a period not to exceed ninety days. If, prior to the expiration of the court commitment, the treatment team feels the patient is not ready to leave the hospital, they may apply for continued treatment. If the patient is well enough to leave the hospital, he or she may be discharged at the expiration of the court commitment order. Transfers under interstate compact usually occur when the patient is a former Vermont State Hospital patient (this is not a necessary condition, however) and is in an institution in another state. When both states' Departments of Developmental and Mental Health Services agree that it would be in the best interest of the patient to return him or her to this hospital, the patient is transferred on a "transfer under the interstate compact." The patient must be committed to the hospital in the other state since voluntary patients cannot be transferred under this compact.

Of the 14 VSH admissions with a legal status listed as "other" in this report, 6 were involuntary court orders for 90 days, 5 were a revocation of conditional release, one was a guest, and 2 were interstate compact.

21. Type of Admission

Patients reported as first admissions to the Vermont State Hospital have had no previous admissions to that institution. Patients reported as readmission have previously been admitted to the hospital, although those admissions may not have occurred during the report period. The reader should keep in mind that the length of stay of first admissions includes all of the time these patients have spent in the Vermont State Hospital while the length of stay of readmission includes only the current admission, which may be only a fraction of their total time in the hospital.

22. Discharge Rate

The discharge rate for clients admitted to the Vermont State Hospital during FY2002 (Tables 3-14 through 3-19) is based on the number of days between each patient's admission to the hospital and his or her discharge. Patients discharged six or fewer days after their admission are reported as discharged within 1 week, patients discharged 13 or fewer days after their admission are counted as discharged within 2 weeks, etc. It should be kept in mind that these discharge rates are cumulative, not mutually exclusive. Patients counted as being discharged within one week of their admission are also counted as being discharged within two weeks of their admission, etc.

23. Length of Stay

Two measures of the length of stay of patients in residence at the Vermont State Hospital at the end of the fiscal year are presented in Tables 3-20 through 3-25. The arithmetic "mean" is derived by adding the length of time between each patient's most recent admission and the last day of the fiscal year (June 30, 2002) and dividing the grand total by the number of patients in residence at the end of the year. The "median" length of stay is the time between the most recent admission and the end of the year for the patient who had been at the hospital as long as half of the patients in residence. The median is the fiftieth percentile.

At any given time, many patients will have been in the hospital relatively short periods of time while a few patients will have been in the hospital for very long periods of time. Because of this the distribution of lengths of stay is "skewed to the right." In this situation the mean is always greater than the median. The arithmetic mean presents a more accurate picture of the total utilization of the Vermont State Hospital by all patients in the various categories reported, while the median presents a more accurate picture of the length of stay of individuals in the categories.